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# Sentinel Event Newsletter

Division of Licensing and Certification  
Maine Department of Health and Human Services



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## Sentinel Event Alert #62—Pandemic Special Edition

In February, 2021, the Joint Commission released alert # 62 which reflected on “Voices from the pandemic: health care workers in the midst of crisis”. As we see variants emerge and cases surging again, it may be prudent to revisit to this alert.

A few ways to support health care workers include:

- Foster open and transparent communication to build trust, reduce fears, build morale and sustain an effective workforce.
- Provide clinicians and others with opportunities to collaborate, lead and innovate.
- Remove barriers to health care workers seeking mental health services and develop systems that support institutional, as well as individual resilience.

[Read full article here](#)

# Becker's Clinical Leadership & Infection Control

## 10 Top Patient Safety Issues for 2021

Becker's editorial team chose 10 patient safety issues for healthcare leaders to prioritize in 2021. They are presented in no particular order, based on news, study findings and trends reported in the past year.

A few items that made the list include:

- Healthcare staffing shortages
- Missed and delayed diagnoses
- Surgical mistakes

[Download Becker's report here.](#)

## Conversation Starter– To Prevent Infections in Dialysis Patients

US CDC has a handy guide that may be a useful resource to improve awareness of patient safety issues.

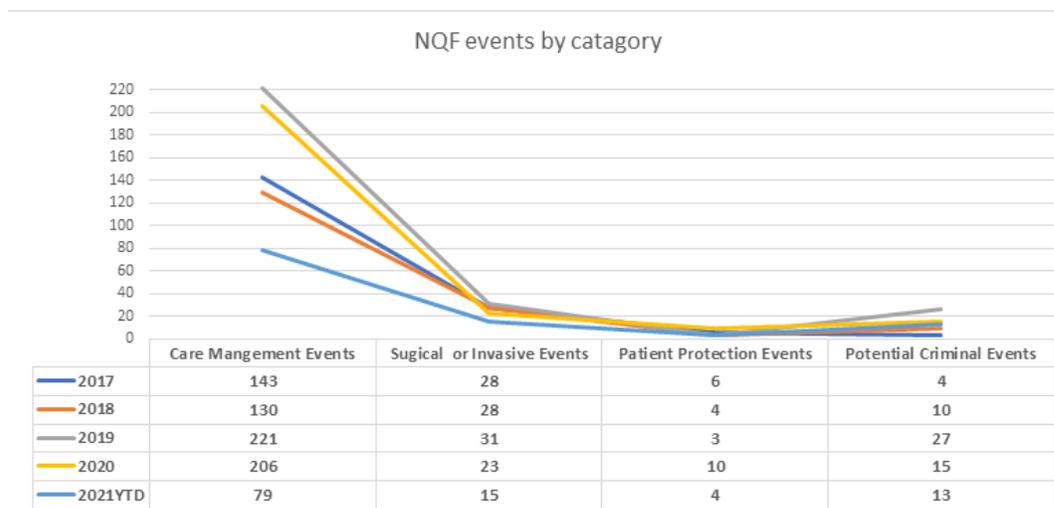
Preventing infections is important for patient safety. The US Centers for Disease Control and Prevention (CDC) wants dialysis patients and dialysis centers to start a conversation about preventing infections. Family members can also start the conversation. We hope this guide can be a starting point to improve awareness about patient safety issues.

Open the Guide [here](#).

## By the Numbers:

The Maine Sentinel Event Notification and Near Miss Reporting Form has state events listed on the front of the form and National Quality Forum (NQF) events listed on the back.

DLC staff recently performed an analysis of NQF sentinel events that occurred in Maine over the past five years. The majority of cases were captured in four of the seven NQF categories. The top four categories along with the number of cases is shown below.



## Learning from Experience: Sentinel Event Reportable Falls

DLC is sharing findings from recent root cause analysis' submitted by licensed health care facilities to provide information that Maine health care facilities have found useful in preventing sentinel events.

### Falls related actions

- Universal precautions-signs on walls, bracelet, inspect room for safety (fall/trip hazards)
- Risk factor assessments: Medications, mental acuity, medical fall risk assessments (Morse Fall Scale, Hendrich II Fall Risk Model)
- Care Planning: Develop an individualized plan of care based on fall and injury risks
- Frequent rounding to prevent patients getting up without the assist needed
- Post fall assessments (mini RCA), Create a Falls committee

## Rules Review: SE Notification & Near Miss Reporting Form

The State of Maine DHHS requires that a department approved notification form is used to notify the SET of a sentinel event or near miss.

Details of this standard are included in the [Rules Governing the Reporting of Sentinel Events](#), page 10.

The relevant rule states:

- 3.2.2** Within 1 business day of the discovery of a sentinel event, the healthcare facility must send the department-approved sentinel event notification form to the SET by fax or encrypted e-mail.

Notification Form reminders:

- Complete as much of the form as possible
- Identify state **or** NQF for event type
- Relevant information to describe the event (enough to understand the event but not a total history)
- Call the SET with any questions on completing the form

### Sentinel Event Team

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